Arizona Dept. of Health Services Division of Behavioral Health Services

Encounter Tidbits

Arizona Department of Health Services

March 2004

Encounter Tidbits is a monthly publication of the Arizona Department of Health Services, Division of Behavioral Health Services, Office of Program Support Services
150 North 18th Avenue, 2nd Floor, Phoenix, AZ 85007
www.hs.state.az.us/bhs

HIPAA Corner. . . .

More About Protected Health Information…

Complaint means any concern communicated by a person questioning any act or failure to act relating to an enrolled person's rights to access his/her Protected Health Information or other information in the designated record set to maintain the privacy of his/her health information, to request restrictions on uses or disclosures of his/her Protected Health Information or other information in the designated record set, to request confidential communications regarding his/her Protected Health Information or other information in the designated record set, to request amendment of his/her Protected Health Information or other information in the designated record set, or to receive an accounting of disclosures of his/her Protected Health Information.

Grievant means the enrolled person who initiates a complaint or grievance.

Grievance means a formal request for review of a HIPAA Privacy complaint or further review of any unresolved complaint related to an alleged HIPAA Privacy violation emanating from a member of the ADHS/DBHS workforce that may be initiated orally or in writing.

Family Member - Under A.R.S. 36-501 (14), "family member" means a spouse, parent, adult child, adult sibling, or other blood relative of an enrolled person undergoing treatment or evaluation.

Fraud and Abuse Reporting Protocol

DBHS would like to remind all T/RBHA and provider staff's that any allegations of fraud, waste, or abuse must be referred to the Compliance Officer immediately upon discovery. DBHS will determine the next course of action for any referred cases. It is also imperative all RBHA employee's, providers, and members, know how and where to report suspicious activity.

In addition to reporting fraud at the RBHA level, anyone who wishes to report a possible incident of fraud, waste, and/or abuse may do so anonymously by calling Stacy K. Mobbs, DBHS Compliance Officer, at (602) 364-4708 or (602) 364-3758, *toll free* at 1 (866) 569-4927, or by e-mail at smobbs@hs.state.az.us.

If you prefer, you may write to us at:

Stacy K. Mobbs, Compliance Officer
Arizona Department of Health Services/BHS
150 N. 18th Avenue, 2nd Floor
Phoenix, Arizona 85007

Edit Alerts

An Edit Alert is a faxed and e-mailed notice of system enhancements or changes. The Office of Program Support strives to ensure any system enhancements or changes are communicated to all program participants in an accurate and reliable manner. Edit Alerts will be distributed when the information is first made available and again with the following monthly publication of the Encounter Tidbits.

Void/Delete Process Change

In order to ensure the success of encounter data submission to ADHS/DBHS and AHCCCS, the pend deletion process has been changed. If an AHCCCS pended encounter needs to be deleted the RBHA must submit a void request to DBHS. The CIS system will automatically create the delete to send to AHCCCS if applicable. This change will not only ensure that both CIS and the PMMIS systems are in sync but also eliminate the additional step of having to follow-up the deletion with a CIS void. It will be the responsibility of the RBHA to document the reason the encounter was deleted and maintain a record of the deleted ICNs, and upon request, make this documentation available to ADHS/DBHS for review. However pended encounters must not be deleted in order to avoid sanctions for failure to correct pended encounters within 120 days.

Deletion and Override Logs

RBHAs must develop and maintain a delete and override log for all claims/encounters from providers to RBHAs and from RBHAs to DBHS. This log must indicate appropriate reasons for the delete or override. Upon request, the RBHAs are able to make this documentation available to DBHS for review in electronic file format. Encounters that have been voluntarily deleted are stored on the CIS database with a status code "DE" indicating that they were deleted by the RBHA. Encounters must not be deleted or overridden in order to avoid sanctions for failure to correct pended encounters within 120 days.

At a minimum the logs must contain the following information: RBHA ID, AHCCCS CRN Number, ICN Number, Line Number, Dates of Service (Start and End), Provider ID Number, AHCCCS Error Code, Record Type, Deletion/Override Reason.

NOTE: Please see last page of the newsletter for the file layout.

Intake/Enrollment Overrides

Effective March 1, 2004 the T/RBHAs will be required to keep an override justification log for all intakes submitted with no Client ID and an Action Code of "O". The log must list client ID matched, matching field and documentation/reason for determination client was not a match.

Important Reminders . . .

Data Validation Study CY20

During the Medical Record Review phase of the study, the errors the analysts record are Omission, Correctness, and Timeliness.

An ***Omission error*** is assessed when the provider documentation indicates a service was rendered, but an encounter was not submitted.

A ***Correctness error*** is assessed when there is a discrepancy between the provider documentation and the information submitted on the encounter.

Correctness errors can only occur when an encounter can be matched to a corresponding medical record service. If the service coding agreed upon by the analysts does not match the encounter data submitted a correctness error is recorded. One of the top errors seen in past studies is the diagnosis code is not taken out to the 4th and 5th digit or the diagnosis code does not match the documented diagnosis written in the chart notes.

A ***Timeliness error*** is assessed when an encounter is received at AHCCCS more than 240 days after the end of the month in which the service was rendered.

The AHCCCS Encounter Reporting Validation System (ERVS) automatically determines timeliness errors by comparing the date of the end of the month in which the service was rendered to the encounter submission date, if the time elapsed is greater than the 240-day deadline then a timeliness error is recorded.

NOTE: Timelines are determined by the date AHCCCS receives the encounter, not the date the Health Plan received it.

AHCCCS Pended Encounters

AHCCCS is targeting March 2004 to begin processing new encounters again. Since November 2003, they have only been processing "recycled" pended encounters (records that have not been changed online or processed in the Deletion/Override file).

Encounters with Multiple Client IDs Cleanup

Encounters that have been adjusted using a different Client ID than the one submitted on the original encounter need to be researched and cleaned up by 03/31/2004 to ensure that the proper Client ID is associated with each encounter. Adjustments are no longer accepted into CIS when the Client ID or Provider ID does not match the original encounter. Data files for each RBHA were provided on 09/25/2003 (2003 data) and 11/07/2003 (2002 data).

Identification and Investigation of Fraud and/or Abuse of the Behavioral Health Care System

Periodic audits need to be conducted, following the baseline sampling methodology, at frequent intervals to ascertain compliance with applicable fraud and abuse requirements. The periodic audit also should be used to ascertain whether the compliance plan is being followed. The goal of these audits should be to assure personnel competency and uncover improper claims activity (patterns of improper activity in particular) before the point where potential violations may be significant enough to warrant government-imposed penalties. An effective periodic audit process must include a means to provide feedback to the individuals involved in the various phases of claim development and submission.

Organizations need to be prepared to conduct complaint audits in response to employee or patient complaints or other evidence of possible improper billing practices. Failure to respond promptly to a complaint raises questions to an organization's commitment to compliance. In addition, a complaint to an organization has the potential of reflecting a complaint also may be filed with the federal government. Complaints must be taken very seriously, and individuals need to understand they may make complaints without fear of retribution.

In accordance with ARS § 36-2918.01, the Contractor or subcontracted providers are required to notify the ADHS/DBHS Office of Program Support or the AHCCCS Office of Program Integrity immediately of all suspected fraud or abuse. The Contractor has ten working days from the date of discovery to inform the ADHS/DBHS Office of Program Support or the AHCCCS Office of Program Integrity in writing of instances of suspected fraud and/or abuse, including incidents that were resolved internally but involved AHCCCS funds, ADHS, the Contractor, or subcontracted providers.

Important Definitions for Corporate Compliance

Anti-Kickback Statute, 42 USC § 1320a-7b(b), applies to health care programs funded wholly or in part with federal funds. Criminal punishment – maximum prison sentence of five years and fines up to ***$25,000 per violation***.

1. Elements – to solicit, offer, or receive any remuneration in return for referring an individual or to purchase lease, order or arrange for any item or service for which Medicare or Medicaid may make payment in whole or in part.
2. Intent – knowingly and willfully

Provider means a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or effective November 1, 1983 through September 30, 1986, a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has a similar agreement but only to furnish outpatient physical therapy or speech pathology services (42 CFR § 1000.20).

Billing Questions …

Consultation Services … … …

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The consultant may initiate diagnostic and/or therapeutic services during the same or subsequent visit. Requests for any consult should be well annotated in the patient's medical record to preserve continuity of care and, if needed, prove all steps were taken to prevent any incident of fraud, waste, or abuse of funds. The consultant's opinion and any services performed must be well documented in the patient's medical record and communicated by written report to the originating physician or other appropriate source.

Any consultation not initiated by a physician, is not reported using the initial consultation codes, but rather they are reported using the codes for a 'Confirmatory Consultation, New or Established Patient'. A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice *only*. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care.

Any specifically identifiable procedure performed on, or subsequent to, the initial consult should be reported separately. If subsequent to the completion of any consultation, the consultant assumes responsibility for management of all or part of the patient's care, the follow-up visits cannot be billed using the consultation code set. In most instances, the appropriate established patient codes should be used.

There are four subcategories of consultations: office, initial inpatient, follow-up inpatient, and confirmatory.

Office or Other Outpatient Consultations (New or Established Patient)

99241	Requires these 3 key components: a problem-focused history; a problem focused examination; and straightforward medical decision-making for a self limited or minor presenting problem. (Approx. 15 minutes)
99242	Requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and, straightforward medical decision-making for problems of a low severity. (Approx 30 minutes)
99243	Requires 3 key components: a detailed history; a detailed examination; and, medical decision-making for a problem of low complexity for a problem of moderate severity. (Approx. 40 minutes)
99244	Requires 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity for problems of a moderate/high severity. (Approx. 60 minutes)
99245	Requires 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of high complexity for a problem of high severity. (Approx. 80 minutes)

Confirmatory Consultations (New or Establish Patient)

99271	Requires these 3 key components: a problem-focused history; a problem focused examination; and straightforward medical decision-making for a self limited or minor presenting problem. (Approx. 15 minutes)
99272	Requires these 3 components: an expanded problem-focused history; an expanded problem-focused examination; and, straightforward medical decision making for a problem of low severity.
99273	Requires 3 key components: a detailed history; a detailed examination; and, medical decision-making for a problem of low complexity for a problem of moderate severity. (Approx. 40 minutes)
99274	Requires these 3 components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity for a problem of moderate to high severity.
99275	Requires these 3 components: a comprehensive history; a comprehensive examination; and, medical decision-making of a high complexity for a problem of moderate to high severity. (Approx. 80 minutes)

TRBHA Pharmacy Network Providers

All Title XIX/XXI eligible and enrolled members of Tribal Regional Behavioral Health Authorities (TRBHAs) have access to receive covered behavioral health prescriptions through RxAmerica's Pharmacy Provider Network. Consumers and providers must be aware that only psychotropic medications are provided on the approved psychotropic medication formulary. This list can be accessed through the ADHS/DBHS website at http://www.hs.state.az.us/bhs/md/medlist.pdf.

All three TRBHAs have access to RxAmerica's Pharmacy Provider Network and they have pharmacies located in rural and metro areas, for more information, please see their website at http://rxamerica.com/. In addition to the standard formulary and provider locations, the TRBHAs have the ability to customize the approved medications and the pharmacy provider network by requesting the change through the TRBHA Coordinator.

To obtain a list of RxAmerica participating pharmacies, contact Terri Speaks at either (602) 364-4701 or via email speakst@hs.state.az.us. If the TRBHA desires to utilize a pharmacy not part of the RxAmerica provider network, the decision to add the pharmacy to the network rests with AHCCCS. RxAmerica indicated some pharmacies would not accept the fee for service rate set by AHCCCS for covered psychotropic medications.

RxAmerica has been administering the pharmacy network for AHCCCS since 2000. Not only does RxAmerica perform this function but also manages the benefits associated with it. If you need further assistance, please contact the TRBHA Coordinator at (602) 364-4701.

Batch Eligibility Verification

The 270/271 transactions are now available on the WEB for batch client eligibility verification. AHCCCS requests that everyone test the new transaction with them before attempting to use the new process. To arrange for testing please call (602) 417-4451 or send an email to isdcustomersupport@ahcccs.state.az.us.

User Access Request Forms

The Office of Program Support Services must authorize all requests for access to CIS, Office of Human Rights, Office of Grievance and Appeals, Issue Resolution System, and PMMIS (AHCCCS) databases. In order to obtain access to any of these databases, please fax or mail a copy of the appropriate User Access Request Form and User Affirmation Statement to Stacy Mobbs at (602) 364-4736. For questions or more information, please contact Stacy Mobbs by telephone at (602) 364-4708 or by e-mail at smobbs@hs.state.az.us.

Who's Who in the Division of Behavioral Health…

The Office of the Medical Director

The Office of the Medical Director provides clinical oversight in the provision of behavioral health services. Working closely with the Medical Directors of the RBHAs, the Office of the Medical Director establishes guidelines for treatment services and quality of care throughout the State. The Office of the Medical Director also chairs a multi-disciplinary committee of clinicians from other State agencies, RBHAs, and providers to develop service planning guidelines and recommendations for best clinical practices. The Medical Director coordinates with the AHCCCS Medical Director and AHCCCS Health Plans for the joint management of clients' physical and behavioral health needs. The Associate Medical Director is responsible for children's behavioral health issues.

Medical Director: Dr. Jerry Dennis
Associate Medical Director: Dr. Ray Lederman

CIS Pended Encounter Maintenance Screen

RBHAs will no longer be able use the online CIS "AHCCCS Pend Maintenance Screen (H74991)" to change the Action of a pended encounter to "D" (Delete) or "A" (Approved Duplicate Override). Pended encounter deletions and approved duplicate overrides should be submitted in the monthly DELDUPyyyymm_rr.TXT file. Once the new deletion process is established, only approved duplicate overrides will be submitted in the monthly file. RBHAs will only be able to change the Action to "N" (No Action) or "C" (Online Correction).

AHCCCS Encounters Error Codes

Z575 – Date of Service Already Billed on an Outpatient from Different Health Plan

Generally, this is a result of two encounters for one service submitted by two plans. Contact the other plan to determine if there are overlaps in dates of service; and who should have paid for the service or how much of the service. If you need further assistance, contact your technical assistant.

This one error accounts for 25.00% of the pended encounters at AHCCCS.

Office of Program Support Staff

If you need assistance, please contact your assigned Technical Assistant at:

Stacy Mobbs	Gila River Navajo Nation Pascua Yaqui	(602) 364-4708
Michael Carter	NARBHA PGBHA	(602) 364-4710
Eunice Argusta	CPSA-3 CPSA-5	(602) 364-4711
Javier Higuera	Excel Value Options	(602) 364-4712

Claims and Encounters
Deletion & Override Log

In conjunction with the Edit Alert published on 2/12/2004 and amended on 2/26/2004, this outlines the requirements for the electronic file format for the Deletion and Override Log.

The log file (fixed length, no commas or quotes) will be called DelOvrdLog_yyyymmdd_rr.txt (yyyymmdd is the 4-digit year, 2-digit month, and 2-digit day of the log's creation date, rr is the 2 character RBHA ID (zero filled)). Example: For Excel's log file created 4/30/2004, the file name would be DelOvrdLog_20040430_03.txt. The file will be submitted by the RBHA via the NT server in the following format:

Record Layout

329 Column Format

Update Date: 02/26/2004

Field Name	Type	Actual Positions From	Actual Positions To	Remarks
RBHA ID	X(2)	01	02	Zero filled
AHCCCS CRN Number	X(14)	03	16	
ICN Number	X(11)	17	27	
Line Number	X(2)	28	29	Zero filled
Start Date	X(8)	30	37	YYYYMMDD
End Date	X(8)	38	45	YYYYMMDD
Provider ID Number	X(6)	46	51	
AHCCCS Error Code	X(4)	52	55	
Record Type	X(18)	56	74	Values: "Claim Deletion", "Claim Override", "Encounter Deletion", "Encounter Override"
Deletion/Override Reason	X(255)	75	329	Description of reason for deletion or override